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THE JOURNAL OF SCHOOL HEALTH

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VOL. VII FEBRUARY, 1937 No. 2

A PHILOSOPHY OF HEALTH EDUCATION*

By Professor S. A. Courtis

School of Education, University of Michigan

In this age of New Deals and confusion, the only contributions an outsider can make to a group of specialists is to describe the general changes that are taking place in all education and to express the views of the "average citizen" as to the particulars in which general criticisms seem to apply to Health Education.

In education generally, the confusion arises from a struggle between the conservative and the progressive views. Conservatives believe both that a child should "learn" something from his school work and that they know what is "best" for the child to learn. The progressives are convinced that what kind of a man a child grows up to be is more important than what he knows. They are concerned with the integration of personality. The conservatives face the past; the progressives face the future. One believes in teaching solutions; the other in developing problem-solvers. One peddles knowledges; the other, methods of attack.

The real conflict, however, is more apparent in the "how to teach" than in the "what to teach." Both may give lip service to the same verbal statement of aims; but in the classroom the difference is at once apparent in what they do. The traditionalists conduct an autocratic school; they give orders, demand memorization and conformity, measure success by the possession of knowledge and skill, make use of extrinsic rewards and motives, discipline through force and punishment and point to achievements as proof of the success of their efforts. The progressives believe in democracy. They provide for co-operative participation by the child in school government. Progressives are concerned with stimulating vision and purpose, with child directed planning, assignment, and appraisal, with co-operative interpretation and generalization. They respect individual differences and permit each child to grow at his own rate, to his individual objectives and to learn his own way. Their chief concern is to develop life attitudes, ideals, and purposes. They try to stimulate self-directed choice in

*Read before the Institute on Health Education, University of Michigan, and the Third Annual Meeting of the Michigan Association of School Physicians, Ann Arbor, Michigan, May 16, 1936.

terms of fore-knowledge of the consequences of action, and they use the children themselves as exhibits, not the products of the children's activities.

If Health Education were to "go progressive" it seems to an outsider as though there would be need for many changes. All teachers in a progressive school have a common aim and work together to achieve that aim. Health Education teachers would have to know what every other teacher in the building was doing, and would have to try to contribute to those efforts. Conversely, he would have to desire the contributions of those other teachers to his own work. Such unity of aim and effort is neither an achievement of our present day schools, nor judging by such behavior as I have seen, an ideal of Health Education teachers.

The specific activities of Health Education seem to be four in number.

The first of these is responsibility for securing the development of children who are structurally perfect. This aim can only be achieved if Health Education teachers accept a much wider field of responsibility than at present. Food, clothing, hygienic service to body, mind and soul, and hygienic social relationships are all essential to health. Other teachers are handicapped in their educational efforts both by lack of knowledge of the stage of development attained by their pupils and by the positive ill health or defects in the children. From the view of an outsider, health education teachers conceive their task entirely too narrowly. Unhygienic conditions in toilets, classrooms, playgrounds and homes should stir them to action. There should be continuous records of child development from kindergarten through college to serve as a basis of diagnostic study. Today athletics, pools, lockerrooms, and playgrounds are productive of more colds and contagious diseases than the puny health education programs cure.

The second obligation is to develop in children the "will to maintain" the perfection of structure and the perfection of functioning engendered by the nurturing care exercised by Health Education teachers through their specific activities and their influence upon all teachers and every form of school work. One educational philosopher has summarized the aim of education in three small words—"see, can and will." The "can" side of education has been well stressed, but the "see" and particularly the "will" have been almost entirely neglected. A new deal in health education would give the arousal of purposes, and the stirring of wills to action equal place with training for the development of skill.

The third obligation is to teach a philosophy of recreating as well as to develop interest in exercise, games, and sports. America is becoming a victim of self-indulgence. The ancient controls contributed by religion are weakening. Smoking, drinking, gambling, sex irregularities, are on the in-

crease. Life is conceived narrowly in terms of immediate pleasure. Co-operation in games, team work, and similar activities might be used to generate a different ideal. No other department in the school has so great an apportunity to develop the ideals of devotion and self-control, which would offset our present tendencies toward self-indulgence of primitive instincts and of egotistic display.

The fourth obligation is to bring into education the same attention to social health that has been suggested as essential for individual health. The average citizen regards government activities with respect to health as imposed, autocratic regulations. This view will prevail until pupils in high school study life problems, and decide what to do about them. The progressives stand for the closest possible tie-up between Departments of Health, Parks and Boulevards, of Safety, of Recreation, etc., and the school, with students serving as research agents for the formalization of problems and the devising of solutions.

There is one aspect of Health Education which the profession apparently does not consider. If Health Education really dealt with life problems, and if it were one hundred per cent efficient, the work of doctors, druggists, hospitals, lawyers, police, and politicians would be so greatly decreased as to practically eliminate such services. Have these professions the devotion to the cause of human betterment which would lead them to *desire* to crucify themselves, and have they the *courage* to do it? Certainly when all children are well-born, well-nurtured, and arrive at maturity with desirable and dynamic individual and social health purposes, and the will to achieve them, the Kingdom of Heaven on earth will have become an actuality, rather than the vague dream it is today.

* * * * *

"Nothing so much worth as a mind well instructed."

* * * * *

Haven Emerson, M.D., Vice-President, American Association of School Physicians, Practitioner of medicine, teacher of physiology and physical examinations, and attending physician at hospitals and dispensaries, 1901-1914; Deputy Commissioner and Commissioner of Health of the City of New York, 1914-1917; Medical Corps, United States Army, Major, Lieutenant-Colonel, 1918-1919; Epidemiologist, American Expeditionary Forces. Medical Adviser of the Veteran's Bureau, 1919-1920; Professor of Preventive Medicine at Cornell University, Ithaca, 1920-1921; Professor of Public Health Practice, College of Physicians and Surgeons, Columbia University, 1921, to date; Consultant in Public Health Practice, and director of surveys of hospitals and health in various cities in this country and abroad.

THE ESSENTIALS OF A SCHOOL HEALTH EDUCATION PROGRAM*

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Secretary, School Health Education, National Tuberculosis Association

Health education has been the first objective of education since 1918. In some form or other, instruction in health is now required in forty-five states. It still, however, occupies a minimum place in the school curriculum, though it certainly does or could make a maximum contribution to effective living.

The present aim and tendency is to broaden the conception of school health education to include emphasis upon the physical, mental, social, and emotional aspects of health, and to interpret health education as a way of living as well as a subject to be taught.

This philosophy demands that the school program include learning experiences which provide (1) for healthful school living; (2) for health service, and (3) for health instruction. These three divisioins I wish to discuss briefly.

Healthful School Living concerns itself with wholesome physical environment; with the organization of a healthful school day; and with the establishment and maintenance of such teacher-pupil relationships as will give opportunity for the development of all pupils.

A healthful school plant includes a site adequate in size and free from health menaces, a building adequate in size and constructed of fire-resistive material. The school building should be planned and built to provide for hygienic lighting, heating, ventilation, seating, water supply, toilet facilities, hand washing arrangements, cloak rooms, lunch room, rest rooms for pupils and teachers, playgrounds and play equipment. Last, but not least in importance, a health room where the school physician and the nurse may center their activities is essential.

The organization of a healthful school day is of fundamental importance if children are to accomplish a maximum amount of work with the accumulation of a minimum amount of fatigue.

Factors entering into a hygienic daily schedule are: The *length of the school day*, which should vary to meet the needs of the age level of the children. Usually one session is recommended for primary grades. A longer day, with rest and relaxation periods when needed, will better suit the needs of older children. The length of the class periods should be determined on the basis of the span of attention of the age and grade level of the pupils.

Sequence of subjects should provide for variety, change, and zest all

*Read before the tenth annual meeting of the American Association of School Physicians, New Orleans, La., October 21, 1936.

through the school day. Thorndike explodes the theory of mental fatigue. He claims that we suffer from boredom or monotony.

Rest and relaxation periods should be used to break long periods of strain or inactivity. Techniques in rest and relaxation should be developed in early years and adhered to throughout the grades. *The physical education period* is adapted to needs of children. In primary grades they are shorter and scheduled oftener. When physical disability requires it, complete rest or a modified activity program should be required.

The lunch period should give adequate time for children to eat slowly, visit the toilet, and wash their hands. Supervised study periods should be ample to furnish guidance in all subjects in which children need help. A maximum amount of time should be devoted to the assignment and preparation of lessons and a minimum amount of time given to recitation.

Home study often becomes a health menace because of poor lights, poor desks and chairs, difficult and poorly assigned lessons, noise and home chores, and poor study habits. It is therefore desirable to send a minimum amount of work home in the first six grades.

Pupil-teacher relationship. Of great significance is the teacher's influence upon a child's personality and hence upon his health, since health is a condition of the whole individual. The teacher may excel or fail in promoting a healthful reaction of the child to the daily tasks and responsibilities of school life, in proportion to her knowledge of the principles of child development and her interest in the welfare of her own group.

The school should be conducted to eliminate, as far as possible, fears in children, and to promote in them self-confidence, self-respect, and self-direction. Fear is often held responsible for numerous types of abnormal behavior, such as jealously, types of delinquency, slowness in development, and untruthfulness.

The whole classroom experience should be guided by the principles of individual differences. Children are not all alike. They vary in their strength, endurance, resistance to disease, likes and dislikes, visual and auditory acuteness, intelligence, educability, memory power, and others. The well informed teacher will not expect the same performance from all children. As certain pupils are seated near the front because of auditory or visual defect, so pupils with limited strength will be protected from the more exacting demands of effort.

Success and failure cause emotional instability of the individual. Continual failure leads to despair; continual success to over-confidence. The daily classroom experiences should give opportunities in which every child may experience real success from time to time. Knowledge of successs favors learning. Boys and girls who fail constantly because of unsuited

courses of study are learning to fail in life. The mental effect of continuous failure tends to destroy self-confidence. Cubberly says, "The important thing to do for every pupil is to so place him that his ability to work will be most deeply challenged."

In recent years, more attention has been directed to attempts to lessen noise and excitement in and around schools. Studies have shown a relationship between noise and fatigue. The noisy school does not offer favorable conditions either for learning or for healthful school living, and hence the conditions of the classroom that favor quiet and poise in pupil and teacher are important for health. Excitement among pupils is apt to be present when noise exists in marked degree. Voices are raised in attempts to communicate ideas or express emotions, with resulting strain and tension.

Some teachers produce tension and excitement in children by loud, high pitched voices. In an effort to keep children quiet, a badly trained teacher may talk loudly, in a rasping voice, threatening children. This is not only poor teaching, but a violation of hygiene. The newer methods of teaching are conducive to improved pupil-teacher relationship. Our concern today is not so much what we are teaching, but how we are teaching it. Education today is thought of as the process by which the individual student discovers and develops himself. The teacher's function today is to serve as a stimulator and guide in the learning process. In the new schools there is more learning and less teaching, more study and preparation and less reciting. Directing study is fast taking the place of hearing lessons. The teacher is vitally concerned with the pupil's habits of study and with the guidance of activities that call forth the best efforts of all children.

Health service is the second phase of the school health education program. It comprises all those procedures used to determine the health status of the child; to enlist his and his parent's co-operation in the correction of defects, the prevention of disease, and the protection of health.

The technical work is carried on by medical, nursing, dental, psychological, psychiatric, nutritional, and other specialists in close co-operation with educational officers, teachers, parents, and often with various health agencies outside the school.

The health examination directed toward the recognition, correction, and prevention of defects is made by the school physician, the health officer, or the family physician. For best educational results, the examination should be thorough, unhurried, made in the presence of parents, and the defects discussed by physician and parents. The nurse or teacher may record the findings.

Correction of defects is the responsibility of parents, and may be motivated by thorough explanation of findings by the physician; by classroom

teaching based upon findings of examination; and, finally, by home visits of the nurse or teacher.

Morning inspection has a two-fold purpose. The teacher inspects informally all pupils on arrival at school for signs of communicable disease. Upon detection of deviations from usual health status, the child should be referred immediately to the nurse or physician for further observation and final disposition. Children should be taught to remain at home if they are not well.

Morning inspection for personal appearance is more effective when done by the children themselves. A mirror in the cloakroom may be used. Children may pass unobtrusively through the cloakroom to inspect themselves. Standards of fine personal appearance may be established in this way, and many mental and emotional problems avoided.

Immunization against typhoid and diphtheria and vaccination for smallpox may be used as a part of the school health service program to prevent these diseases. Instruction with regard to the immunization program should prepare pupils psychologically for this program. The tuberculin test should be given as a part of the regular school health examination, and pupils showing a positive reaction should be X-rayed in an effort to identify active tuberculosis in its earliest stage. Teaching should precede this process.

First aid is the phase of health service which aims at safety education, and at adequate attention in case of emergencies. This activity may be a joint responsibility of the teacher and nurse; the teacher guiding children in certain lessons, and the nurse demonstrating certain activities.

To summarize, health service aims at the correction of all remediable defects in every school child and at the control of all communicable disease. Its method is educational to the point that children and parents become self-directive in that they assume the initiative and responsibility for optimum health status of their own children.

Health instruction is the third phase of the school health education program, and is defined as "the organization of learning experiences directed toward the development of favorable health behavior."

There is today a definite trend in general education to break down the traditional lines of demarcation between subjects, and to begin with the needs or interests of the child as a basis for the development of a series of units. Curriculum today is defined as a series of activity-experiences, often called units of instruction.

Certain guides for determining just what activity-experiences the teacher may select are:

1. A thorough knowledge of the physical, mental, social, and emotional characteristics of her pupils.

2. A survey of the health problems and the facilities for teaching in the school, home, and community environment.

3. The findings on the health record cards.

4. The interests of the pupils in the group.

5. The health and safety statistics in a given locality.

6. Observation of personal appearance and health conduct of individual pupils.

7. A survey of health practices in the home, made with the co-operation of parents.

8. A health knowledge test.

Any teacher may use these leads in any teaching situation to find the health status of pupils and of the community in which they live. By making a synthesis of these findings an adequate program of health instruction may be planned. Whether the teaching process is directly done at a stated daily period, or whether health is an integrated process is not of such great concern so long as the program meets the need of the child.

Guides for an effective psychological approach may also be set up. Briefly, they are:

1. Emphasis in the primary grades is placed upon health practices—coming safely to school; adjusting happily to the teacher and pupils at school; participating whole heartedly in play periods; lunch periods; rest periods at school; increasingly accepting responsibility for personal appearance, and the like. Such practices may be motivated by health stories about children in actual life situations.

2. Emphasis in the intermediate grades is upon knowledge or information which rationalizes healthful living, and emphasis upon skills or improved ways of living. Briggs tells us that education should enable children to do better the things they would do anyway. Health instruction in these grades is effective if based upon problems. Children are now able to go in search of answers to their own questions or of solutions of their own problems. Health books are best used as sources or references rather than as texts in which the next chapter is assigned.

3. In the Junior high grades emphasis may take the form of motive for fine living. Ideals, attitudes, appreciations may be developed during the hero-worship age. Community problems may be studied. Satisfactory individual and group relationships may be developed. Instruction is much richer at this age if integrated with other subjects.

4. In the Senior high school the power to think may well be emphasized. Hollingsworth has said, "The major problems of every generation of youth are: Choosing a vocation, gaining independence from the home, establishing friendly relationship with the opposite sex with the eventual objective of marriage, and building a philosophy of life." These and

many other problems furnish a basis for investigation, and opportunity for thinking through one's own difficulties which relate to more effective living.

In the senior segment, health instruction is being well done in two ways. If there is definite time in the curriculum, and if there is a well trained emstructor, a series of units may be developed using the problems of this group as a basis for study. If there are no such facilities, each subject in the high school may contribute definite health units, as problems of community living, from Social Studies; family relationship, from Home Economics; control of communicable disease, from General Science; recreation, from Physical Education and personal efficiency, from commercial subjects.

To summarize briefly, health instruction to be most effective is conceived not as the accomplishment of specified lessons of subject-matter, but as a continuous process of activities, closely related to life situations, meaningful and purposeful to pupils, stimulated and intelligently directed by the teacher to the end that pupils develop self-direction, consideration for members of their group, and a richness of personality which will enable each individual to live fully and worthily.

* * * * *

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TUBERCULOSIS IN CHILDREN

Report of the Tuberculosis Committee of the American Association of School Physicians, October 22, 1936

Continued from January Number

Massachusetts.—In 1935, 58,757 children were tested, of whom 20.5 per cent reacted positively. The highest percentage for any county was 37; the lowest 8. In recent years more than 400,000 children have been tested in Massachusetts. Undoubtedly this state leads all others in the testing of school children and in the finding of cases of clinical tuberculosis among them. The Chadwick clinics must have a prominent place in the final history of tuberculosis control in the United States.

FIGURE II—*Number of persons tuberculin tested in Michigan, and percentages of positive reactors, according to counties.*

Michigan.—The report includes all the testing which has been done in the state since 1931. In all, 245,706 children have been tested, 19.2 per cent of whom reacted positively. Fifty-one per cent was the highest incidence of infection in any county and 4 per cent was the lowest. In fact, there are only two counties in the state where testing has not been done. The map submitted to our committee was so satisfactorily prepared that we have asked for permission to reproduce it as a part of our report.

Minnesota.—In this state 46,975 children were tested, of whom 12.2 per cent reacted positively. The highest incidence of positive reactors for any county was 24 per cent; the lowest 2 per cent. In this state more than 300,000 children have been tested during the past few years. This is one of the states that has had a very serious tuberculosis problem to combat, probably because of the fact that in the '60's, '70's and '80's, there was an extensive migration of families with tuberculosis because of the supposed curative value of the climate. Many of these families took up residence in this state and passed their tubercle bacilli on from generation to generation.

Mississippi.—In this state 843 children were tested in 1935, 20.6 per cent of whom reacted positively. The highest incidence of positive reactors was 66.7 per cent; the lowest 14.9 per cent.

Missouri.—Here 7,044 children were tested and 16.3 per cent reacted positively. This does not include all testing, but it was impossible to secure data from one or two local organizations in time for this report.

Montana.—In this state 11,580 tests were administered. For the most part high school children were tested, although a few adults were included. The percentage of positive reactors was 16.2. The highest incidence of positive reactors in any county was 32.5 per cent; the lowest 5 per cent.

Nebraska.—Here 7,902 high school girls and boys were tested in Lincoln and Omaha and 20.2 per cent reacted positively. Nebraska now has a state-wide tuberculosis program and promises to be one of the first states in the Union to control the disease.

Nevada.—In this state tuberculin testing has been done in one county where the incidence of positive reactors was 30 per cent. However, under the maternal and child health program now in operation, a state-wide program of tuberculin testing, particularly of the high school children, is being planned, and it is anticipated that most school children will have been tested by January, 1937.

New Hampshire.—Here 1,454 children in the seventh, ninth and high school grades in both private and parochial schools were tested and 26.7 per cent reacted positively. The highest incidence of positive reactors in any county was 31 per cent; the lowest 14 per cent. A great deal of work has been done on a state-wide basis but it has been concentrated largely

on adult clinics and examination of contacts. However, a program of testing school children on a comprehensive scale is being contemplated in the near future.

New Jersey.—In this state 10,159 children were tested, of whom 24.6 per cent reacted positively. The highest incidence of positive reactors in any county was 51 per cent. The testing was done in special school clinics and in regular community tuberculosis clinics. In a few of the counties, X-ray examination has been employed without the use of the tuberculin test as a screen.

New Mexico.—In this state 5,751 children were tested, of whom 26.4 per cent reacted positively. The highest incidence of positive reactors in any county was 72.5 per cent; the lowest 7.4 per cent.

New York.—A total of 30,954 children were tested and 30.2 per cent reacted positively. The highest incidence of positive reactors for any county was 51.3 per cent; the lowest 12.1 per cent. This does not include all testing done, as it was impossible to secure reports from all local associations. It is of interest to note that in Brooklyn during the spring of 1936, X-ray films were made by the rapid method of approximately 72,000 high school girls and boys.

North Carolina.—In 1935, 82,123 children were tested, of whom 13.6 per cent reacted positively. The highest incidence of positive reactors in any county was 52.1 per cent; the lowest 8.4 per cent. The program of tuberculin testing in North Carolina is one of the very best in the country. In North Carolina more than 300,000 children have had the tuberculin test administered. Moreover, the positive reactors have had X-ray film examination of their chests. The state-wide program is one of cooperation with the practicing physicians and the tuberculosis organizations.

North Dakota.—In this state 137 children were tested and 7.3 per cent reacted positively. No testing is done unless funds are available to make X-ray films of the chests of all of the positive reactors.

Ohio.—In this state 59,908 children were tested, of whom 14.5 per cent reacted positively. The highest incidence of positive reactors in any county was 66.9 per cent. More than 33,000 of these tests were administered in Cuyahoga county, where Cleveland is located and more than 24,000 in and about Toledo in Lucas county. In the latter county, the testing was done as part of a WPA project and X-ray films were made of the chests of the positive reactors.

Oklahoma.—In this state 93,000 tests were administered and 13.6 per cent reacted positively. The highest percentage for any county was 25 and the lowest 6. Permissions for testing were granted in from 50 to 80 per cent. In the Indian groups, where surveys were made, 35 per cent were positive. Among the Negroes 28 to 33 per cent were positive. An interest-

ing observation is that the high infection rate among the Indians does not have much appreciable influence on the rate among the whites in the same areas. This is thought to be due to the fact that the Indians and whites do not associate much in home life, and as a rule Indians do not act as servants in the homes of whites. However, in the areas with large Negro population, the rate among the whites is considerably higher.

Oregon.—In this state, 15,582 children were tested, of whom 8.3 per cent reacted positively. The highest incidence of positive reactors in any county was 35 per cent; the lowest 3.7 per cent. Since the testing program began in Oregon, approximately 70,000 tests have been administered. Even among adults, as determined from the testing of teachers and other school employees, the incidence of positive reactors is only 25 per cent.

Pennsylvania.—In this state 22,617 tests were administered, with 25.7 per cent positive reactors. The highest incidence of positive reactors in any county was 51.8 per cent; the lowest 6.6 per cent. On the basis of tuberculin testing done in Philadelphia, approximately ten years ago, the idea is extant that about 90 per cent of the Philadelphia children become infected by the time they reach the age of eighteen years. One must keep in mind that these tests were administered approximately ten years ago, and also that they include groups of children in sections of the city where one might expect an unusually high incidence of positive reactors. The present report should correct this erroneous impression. A very extensive tuberculosis program is in progress in Pennsylvania.

Rhode Island.—A total of 10,244 children were tested, of whom 21.4 per cent reacted positively. It is of interest to note that on October 15, 1936, this state celebrated the accreditation of its cattle herds.

South Carolina.—In this state 34,740 children were tested and 16.6 per cent reacted positively. In one county the percentage of positive reactors was 55.7; in another 1.9.

South Dakota.—A total of 9,071 children were tested and 4.6 per cent reacted positively. At present, a great deal of work is being done not only to control tuberculosis among human beings but also among cattle. Much opposition has been offered to the cattle control program, so much in fact, that in all probability in 1937 South Dakota will be one of two states that has not been accredited. The State Board of Health has required that every teacher in the schools of South Dakota be adequately examined for tuberculosis.

Tennessee.—Although an extensive tuberculosis control program exists in this state, it was impossible to secure data with reference to the tuberculin test. The records in the office of the Department of Public Health show only the total number of children tuberculin tested. There is no report of the number of positive reactors. The office of the Department of

Public Health expressed the feeling that there is little to be gained by wholesale tuberculin testing of school age groups unless adequate facilities are available for follow-up service, which includes physical and X-ray film examination. Also that there is some question as to whether or not wholesale tuberculin testing is as valuable as was once thought. A very interesting observation from Tennessee is that 10 per cent plus of all children who show any X-ray evidence of tuberculosis have a negative tuberculin test. The Health Department expressed a desire to co-operate with our committee, but found it impossible to do so because of shortage of personnel, etc.

Texas.—Here 24,265 children were tested, of whom 18.5 per cent reacted positively. The highest incidence of positive reactors in any county was 51.7 per cent; the lowest 10 per cent. The county with 10 per cent is in the western part of Texas where there are few Negroes and Mexicans. These counties are also sparsely populated. In Terrant county, where Forth Worth is located, only 15.5 per cent of the children reacted positively. Here there are many Negroes and Mexicans. On the other hand, in the eastern and southern parts of the state, where there is considerable concentration of Negroes and Mexicans, the incidence of positive reactors is quite high. This apparent discrepancy between Fort Worth and some of the eastern and southern counties may be due to the intensity of the tuberculosis program.

Utah.—In this state 2,320 tuberculin tests were administered, of which 8.9 per cent reacted positively. The highest incidence of positive reactors in any county was 34.2 per cent; the lowest 2.9 per cent. All of the counties tested in 1935 were rural. The program provides for far more testing in 1936 than in 1935.

Vermont.—Tuberculin testing of children was limited to two counties. The total number tested was not available but the incidence of positive reactors was 21.3 per cent. However, arrangements have been made for a large volume of tuberculin testing during the next year.

Virginia.—Tests were administered to 2,783 children and 51.7 per cent reacted positively. The lowest incidence of positive reactors in any county was 17 per cent.

Washington.—Here 41, 321 children were tested, of whom 13.8 per cent reacted positively. The highest incidence of positive reactors in any county was 20.9 per cent; the lowest 5.1 per cent. In this state, tuberculin testing is being carried on in nearly all of the counties. The testing program has been extended to many adults, including teachers and other school employees.

West Virginia.—In this state 10,098 children were tested, of whom 17.9 per cent reacted positively. The highest incidence of positive reactors in

any county was 84.6 per cent; the lowest 4.8 per cent. The testing in West Virginia has been done on various groups of children; some were contacts, some grade school children, and others of high school age. A more extensive program is being prepared and in September, 1936, the entire freshman class entering the West Virginia University will be tested and X-ray films of the chests made of all the positive reactors.

Wisconsin.—In this state 22,244 children were tested, of whom 11 per cent reacted positively. The highest incidence of positive reactors in any county was 37 per cent; the lowest 4.4 per cent. In addition to this work there has been considerable tuberculin testing of adults. One of the best tuberculosis programs among American universities is being carried on at the University of Wisconsin.

Wyoming.—In this state 367 children were tested, of whom 32.4 per cent reacted positively. The highest incidence of positive reactors in any county was 50 per cent; the lowest 9.5 per cent. Attention must be called to the fact that the children tested in Wyoming have been for the most part from homes where tuberculosis has been strongly suspected or has actually been known to exist among one or more adults. To date no tuberculin testing exclusively for school children has been done.

TABLE I

State	*Number Tested*	*Per Cent Positive*	*State*	*Number Tested*	*Per Cent Positive*
Alabama	1,459	15.3	Nebraska	7,902	20.2
Arizona			Nevada		30.3
Arkansas	9,259	17.5	New Hampshire	1,454	26.7
California	39,307	22.6	New Jersey	10,159	24.6
Colorado	1,417	17.6	New Mexico	5,751	26.4
Connecticut	3,598	16.9	New York	30,954	30.2
Delaware	684	34.5	North Carolina	82,123	13.6
Dist. of Columbia	2,247	46.4	North Dakota	137	7.3
Florida	15,000		Ohio	59,908	14.5
Georgia	15,560	37.7	Oklahoma	93,000	13.6
Idaho	34,514	8.9	Oregon	15,582	8.3
Illinois	41,750	29.2	Pennsylvania	22,617	25.7
Indiana	10,367	17.5	Rhode Island	10,244	21.4
Iowa	18,442	13.0	South Carolina	34,740	16.6
Kansas	6,011	24.0	South Dakota	9,071	4.6
Kentucky	43,196	10.7	Tennessee		
Louisiana	4,003	22.0	Texas	24,265	18.5
Maine	17,929	9.8	Utah	2,320	8.9
Maryland	1,675	42.6	Vermont		21.3
Massachusetts	58,757	20.5	Virginia	2,783	51.7
Michigan	245,706	19.2	Washington	41,321	13.8
Minnesota	46,975	12.2	West Virginia	10,098	17.9
Mississippi	843	20.6	Wisconsin	22,244	11.0
Missouri	7,044	16.3	Wyoming	367	32.4
Montana	11,580	16.2			

Total number tested 1,124,363

In Table I, we have listed the states, showing the number of tuberculin tests reported to us, as well as the percentage of positive reactors. From this table, one sees that the total number tested is 1,124,363. If one were to add to this, tests that have been administered in the past few years, the number would well exceeed 2,000,000. We are of the opinion that this figure probably does not represent more than half of the tuberculin tests which have been administered. It is a well known fact that a large number of physicians in private practice are now using the tuberculin test routinely. With rapidly increasing interest the time probably is not far distant when the majority of the citizens of the United States will have been tested with tuberculin and adequate physical and X-ray film examinations made for the positive reactors.

WM. P. BROWN, M.D., Albany, N. Y.
HUGH E. BROWNE, M.D., Alexander, Ark.
H. A. BURNS, M. D., Ah-Gwah-Ching, Minn.
H. D. LEES, M.D., Philadelphia, Pa.
J. B. NOVAK, M.D., Chicago, Ill.
W. J. RYAN, M.D., Pomona, N. Y.
J. A. MYERS, M.D., Minneapolis, Minn., Chairman.

* * * * *

Infected Tonsils and Rheumatism in Children. Aitken* declares that there is much evidence in support of the theory that an acute infection of the nasopharynx by hemolytic streptococcus has a definite relationship to attacks of acute rheumatism, and some evidence to support the opinion that chronically infected tonsils have an injurious effect on the rheumatic child in the sense that, although their removal may not prevent the onset of the disease, it does minimize the chance of serious cardiac complications and recurrences. A preliminary tonsillectomy, or one performed early during the course of the infection, may possibly, in the case of arthritis, render the heart less liable to be attacked, but not so in the case of chorea. Tonsillectomy, in the case of carditis following arthritis, seems to have a beneficial effect on the progress of the disease, but not in carditis following chorea. The analysis of 117 cases seems to show that the progress in those cases which did not require tonsillectomy and those in which tonsillectomy was done before the onset of juvenile rheumatism was rather more satisfactory than in those in which tonsillectomy was required at the onset of juvenile rheumatism. The patients who had not been tonsillectomized but who did not require tonsillectomy, had the most satisfactory result, but those who had had complete tonsillectomy before the onset of the disease had nearly as good results. The Journal of the American Medical Association, Jan. 9, 1937, p. 157.

*Aitken, Janet K., "Relationship of Infected Tonsils and Rheumatism in Children", Medical Press and Circular, Long, 1936, p. 373.

EDITORIALS

Si Monumentum Queris, Circumspice!

It is just ten years ago that the American Association of School Physicians was organized. Its growth since then has been amazing, due largely to inspired leadership and to the indefatigable efforts of its Secretary-Treasurer, Dr. William A. Howe. With his recent retirement in this capacity, the organization enters upon what might be termed the second stage of its development, a period that may prove as significant as did the first.

In the short period of ten years, opportunity has been afforded the members of this Association to familiarize themselves with some of the leading problems associated with school health work. Through failure, and adverse circumstances oftentimes, the pioneers in school health work have held tenaciously to their idealism even as they did before there was an organization to promote their professional objectives. Today they are still confronted with difficult problems quite as difficult of solution as any which have been met with in the past.

A survey of recent literature reveals that school health work is far removed from the utopian dreams advanced by the makers of the Children's Charter. For example, let us consider the quality of school health work. Did not the recent School Health Study of New York City point unmistakably to the need for improvement along this line? True, as some will admit, the present situation appears insurmountable, especially in the larger cities. But if the school health worker would be respected in the future, let it not be forgotten that the hasty and veneer-like health work of the past has served only to discredit the work of the public health worker of yesterday. Let it be impressed on Boards of Education that the School Health Service will pay dividends if only adequate support is afforded it. Publicity pays!

In our confusion as to what constitutes good school health work, have we not forgotten to give others the best advice we had? Is it any wonder that untutored laymen, sincere though they may be, have taken advantage of the professional silence of the trained school health worker and filled the literature with scrambled notions as to the contribution expected of the individual trained in the health-medical sciences? Small wonder that trained public health personnel are oftentimes unwilling to hazard a career in the schools at the beck and call of school administrators wholly untrained in the fundamentals of school health work.

Another problem of equal significance is that of definition of school health work. Have we removed the mask from those activities which at present claim the major portion of the budget for school health work? Is the public generally aware of the benefits accruing from the services of well-trained public health personnel? Quite to the contrary, our legisla-

tors and city fathers still think in terms of exercise whenever school health work is mentioned.

These are but a few of the issues confronting the American Association of School Physicians today. The question is, will they continue to remain unchallenged.—E.E.K.

* * * * *

The world is filled with worthwhile things to do. New needs—as well as many old ones—and new projects constantly stare us in the face.

Medical inspection of school children—which is now rapidly developing into a true health supervision and health guidance—is an activity more than one hundred years ago, and was started in the United States nearly a half century ago.

During these years, there has been real improvement in some of its phases, mostly in the field of creating a more healthful environment in and about the school, in making the educational program more fitting, physically as well as mentally, to the mental needs and capacities, and to the social environment of the child, and—owing largely to the enormous forward strides of medical science in the use of serological measures of prevention and cure—in the control of communicable disease.

In the later appearing phases of child health supervision—the detection and correction of physical defects, the adequate provision of special classes and fitting education for the handicapped, and the training and education of the child for happy healthful living—the record is not flattering.

In many communities, year after dragging year, the percentages of physical defects found among school children is reported to be the same. Surely, if school health supervision is efficiently effective, these percentages should diminish regularly, since effective health efforts would bring about correction faster than new entrants add to the number of defects. This should be particularly true in communities having a worthwhile "Summer Round-Up." Here is a mutual duty of school health personnel and of parents. The local practitioner of medicine also has a duty in this matter.

How intensely do we, as school physicians, interest ourselves in the health training and instruction carried on in the schools in which we work? What of the poor, mushy textbooks containing little up-to-date scientific information; do we concern ourselves with their content and selection? What of teachers inadequately trained in the basic sciences necessary for accurate and scientific health information; and of the antiquated, poorly planned courses of study; and of the totally inadequate allotment of time for health instruction—especially in the secondary schools?

What has each of us done to secure the allotment in the school budget of more adequate monies for health supervision? In the city of Pittsburgh, under trained medical leadership and through brilliant organization

and salesmanship, the idea of community responsibility for the health of school children has been so thoroughly sold to budgeting officers that the sum of ten dollars per school child is annually allotted to the Department of Hygiene, operating under the Board of Education. Here is a mark for which to strive.

Truly, if we seek a monument it is necessary only to look about us.

ABSTRACTS

The Open Air School in the United States Since 1908.—Open air schools and classes for delicate children in the United States have been identified largely with the anti-tuberculosis forces. They were initiated nearly thirty years ago through the efforts of voluntary tuberculosis associations, the first class having been established in Providence, Rhode Island, in 1908, by the Providence Anti-Tuberculosis League. By 1930, when the U. S. Office of Education published the report of Arch O. Heck of Ohio State University, on "Special Schools and Classes in Cities of 10,000 Population and More in the United States," 31 states were listed with a total of 1,105 open air classes enrolling approximately 32,000 pupils.

During these years many interesting and significant changes have occurred. At first, unbounded enthusiasm for the virtues of fresh air cast into the background the other factors in the regime of the open air school, namely, extra feeding and rest. But as research in the field of nutrition contributed a better understanding of food values and the needs, along this line, of growing children, the emphasis shifted to nutrition. In many schools special nutrition classes were organized with schedules that closely resembled the open air classes, and their popularity lasted about a decade. Dr. W. R. P. Emerson of Boston, Massachusetts, was largely instrumental in their development.

Provision for rest periods was made as a matter of course in the first open air schools, yet their value too, like extra feeding, was minimized in the general enthusiasm for fresh air. Dr. W. R. P. Emerson remarked* some years ago, that "Continued experience in the treatment of malnutrition leads me to the belief that there is no responsible cause for this condition more frequently overlooked than habitual over-fatigue."

Mental hygiene was an unknown term when open air schools came into being, but the need for providing an atmosphere of security and happiness for the children in these classes was appreciated from the very beginning. The school at Charlottenburg set the example by stating that "Encouragement and praise and as much parental kindness as possible were the means by which these children were to be ruled." In the United States, "the con-

*Nutrition and Growth in Children, W. R. P. Emerson, Appleton and Co., 1922, p. 80.

tagious good spirits of the children and the good fellowship between them and the teacher"† have been characteristic of the open air school. Now mental hygiene is included in all progressive syllabi in health education.

The primary reason for the establishment of open air schools was the prevention and cure of tuberculosis, though various types of physically below par children have usually been included in the enrollment. Methods of selecting the candidates have never been wholly satisfactory. "Underweight" has too often been the chief guide, and by limiting the selection to those children whose appearance plainly showed physical signs of lowered vitality, many a youngster with tuberculous infection, whose health looks give no indication of his need for protective care, has been passed by.

It was in 1924 that the Massachusetts State Department of Health launched its ten-year program for the discovery of tuberculosis in children. At first the children selected for examination were divided into three groups: (1) contact cases; (2) those 10 per cent or more "underweight;" (3) children who looked sick. By 1927 when 50,000 children had been tuberculin tested the significant fact had been established, that so-called "underweight" had nothing whatever to do with the presence of tuberculous infection. Children apparently healthy,—not only "up-to-weight" but even "over-weight" were found to have been infected with tuberculosis to a greater or less degree, though there were no physical signs to give the slightest indication of this. As a result, reliance on weight tables as a guide in discovering children in need of protective care has been abandoned, at least by those who keep in step with the ever growing knowledge in the field of health.

In the past five years the use of the tuberculin test has spread widely over the country and is one of the major activities of the voluntary tuberculosis associations working with the health authorities and with organized medicine in an intensive effort to find the early cases. The National Tuberculosis Association has published a brochure entitled "Procedure for the Discovery and Care of Tuberculous Children," which is an effort to systematize, so far as possible, the methods now in operation.

What effect has all of this had upon the status of open air schools and classes? It has developed a new appreciation of the hazards of childhood and the need of all growing children for protective care, which means an adaptation of the school regime to the child, instead of the other way around. The old open air school schedule is being reorganized and made available to more children. One of the most encouraging things is the provision, notably in Boston, Massachusetts, and in California, of "health adjustment" rooms in school buildings where those children in need of extra rest and feeding may retire at intervals during the school day. The

†Open Air Crusaders, Sherman C. Kingsley, The Elizabeth McCormick Memorial Fund, 1913.

following schedule of the Boston plan indicates its administration advantages, chief of which is that the regular school curriculum is not disturbed, and the children are able to attend their regular grades for more than half of the school day.

9:00-10:00 in regular class rooms
10:00-10:30 rest on army cots in well-aired room; hand-washing
10:30-10:40 lunch
10:40-10:50 outdoors
10:50-11:45 in regular classrooms
11:45-12:45 rest on cots
12:45- 1:05 dinner
1:05- 1:15 outdoors
1:15- 3:30 in regular classrooms

Viewing the situation from the point of view of general education it is a satisfaction to record that the regular school program has profited enormously from the lessons learned from "special" education, as exemplified in the open air schools. The value of fresh moving air in all classrooms is understood, and in many schools pupil committees assume the responsibility of seeing to it that what they have learned about good ventilation is put into daily practice. The importance of good food habits and good health habits is being taught as an integral part of school health education, which has come to be accepted as a fundamental in the curricula of all schools.—Louise Strachm, Director, Child Health Education, National Tuberculosis Association, from Bulletin of Association, Jan., 1937.

* * * * *

Nutrition.—The Health Organization of the League of Nations presents in its last Quarterly Bulletin a report on the Physiological Bases of Nutrition as drawn up and revised by the Technical Commission of the Health Committee at a meeting held in Geneva, June, 1936.

The following are the general recommendations of the report.

A. Although a *simplified* diet may be so constituted from a few protective foods as to be satisfactory, it is a general principle that *variety in diet* tends to safety, provided it contains a sufficiency of the protective types of food materials.

B. *White flour* in the process of milling is deprived of important nutritive elements. Its use should be decreased and partial substitution by *lightly milled cereals* and especially by *potatoes* is recommended. The consumption of an excessive amount of sugar is to be condemned, as it tends to lessen the proportion of protective foods.

C. Milk should form a conspicuous element of the diet at all ages. The Commission commends the tendency manifested in some countries to increase the daily intake up to one litre per day for pregnant and nursing women as well as to provide an abundant supply for infants, chil-

dren of all ages and adolescents. The practice of providing milk either free or at a reduced price to these groups is highly recommended. The ration of milk indicated provides from 75-100 per cent of the total calories during the first years of life, decreasing to about 50 per cent at 3-5 years and to about 25 per cent at the age of puberty. For the older groups, some portion of the milk or meat may be replaced by cheese. The Commission desires to draw attention to the high nutritive value of *skimmed* and *separated milk,* which, although deprived of its vitamin A through removal of the fat, retains the protein, the B and C vitamins, the calcium and other mineral elements. The Commission deplores the large wastage in many countries of this valuable food.

D. Fresh vegetables and/or fruit should always be constituents of the normal mixed diet. Adequate provision of the vitamins other than vitamin D can be readily accomplished by inclusion in diet of optimum amounts of protective foods.

E. The Commission emphasizes the need for provision of *extra vitamin D,* wherever and whenever sunshine is not abundant, especially in the period of growth and during pregnancy. Where the appropriate rich foods are not available, only such *vitamin preparations as are officially controlled and approved* should be permitted. The indiscriminate use of irradiated foods, except in the case of milk, is deprecated.

Problems Recommended for Further Study

A. Assessment of the nutritional state of children.
B. Nutritive food requirements during the first year of life.
C. Minimum vitamin and mineral requirements.
D. Minimum fat requirements.
E. The nutritive and "supplementary" values of the different protein-containing foods, to determine to what extent and in what forms animal protein is necessary for growth and health.
F. The relative nutritive value of different cereals according to the degree of milling.
G. The extent to which the increasing consumption of sugar is detrimental to health.
H. Influence of climate on food requirements.
I. The extent to which diets in common use fall below the standards recommended in this report.
J. The optimum amounts of milk required at different ages.

* * * * *

Cafeterias.—Figures taken from the books and accounts of several New York City school cafeterias show the following percentages of divisions of cost: Management and salary, 22 per cent; food, 65 per cent; overhead, 11 per cent; profit, 1.92 per cent.—*Contact,* December, 1936.

Propaganda vs. Education.—The following interesting comparison between education and propaganda seems to apply with peculiar aptness to health education.

Originally "propaganda" meant simply the propagation or dissemination of ideas, doctrines, principles. Today, in America at least, the term in contrast to "education" implies the dissemination of ideas for selfish or partisan reasons. For the sake of clarity in our own personal point of view, we make the following arbitrary contrasts:

Education	*Propaganda*
1. A process of training in which people *actively acquire* knowledge or skill in some human ability.	1. A process in which doctrines or principles are *instilled into* the minds of people.
2. Teaches people to *think* for themselves.	2. Discourages or prevents thinking by substituting ready-made slogans.
3. Uses every means to discipline primitive desires.	3. Uses every means to arouse and stimulate primitive desires.
4. Trains people to weigh and consider problems before acting—reflective behavior.	4. Promotes instinctive and impulsive action—reflexive behavior.
5. Appeals to reason.	5. Appeals to emotion.
6. Encourages the development of individuality, personality, and self-expression.	6. Attempts to mould the thought of individuals into standard attitudes resulting in standard patterns of behavior.
7. Knowledge is acquired through self-reliant activity.	7. Knowledge is spoon-fed and passively received.
8. Counsels a skeptical attitude toward all problems.	8. Urges one particular choice.
9. Tends to develop extraverted personality.	9. Tends to develop selfish and introverted personality.
10. The benefits derived from education accrue not to the educator but to the "educatee."	10. The benefits derived from propaganda accrue not to the "propagandee" but to the propagandist.

The media through which education and propaganda reach the public are interchangeable—newspapers, magazines, motion pictures, radio, lectures, and even "outdoor advertising" are used by both. It behooves those concerned with publicizing health to be on guard lest the materials they use, the facts they dessiminate, smack of "propaganda."

* * * * *

Health Education for Nurses.—In order to help public health nurses in New York State to learn more about principles of teaching, family case work, and how these may actually be applied to their own daily work, a three-day institute was held for continuation study program group leaders in Albany, Syracuse, and Buffalo. The following is a resume of the discussion.

There has been a tendency to canonize principles of teaching. Unless they can be put to practical use, it was pointed out, they should be discarded. Our aim should be to make the thing we wish to teach a part of

the life of the person being taught. Therefore, in order to teach effectively we must understand the learning process. Learning takes place through activity—through the constant interaction of an individual and his environment. An infant, waving his arm at random, strikes his cold, hard crib. He does this again and again until gradually he learns that by stretching his hand in a certain direction he can touch, grasp, and feel something which is different from his own hands or toes.

William H. Kilpatrick, Ph.D., of Teachers College, Columbia University, states that learning takes place through a changed way of behavior. A boy of ten has developed scarlet fever. The mother has been informed that Richard, her five-year-old, will have to be removed from home immediately in order to continue attendance at school. The moment she stops to consider what she should do, learning takes place. Although she may not realize the steps she is taking in her thinking, she at that moment:

1. Faces the situation—is confronted with a challenge. Shall she send her five-year-old son—never away from home—to her sister's home?
2. Takes account of as many factors as possible
   (a) Richard is not very strong; if he stays home, he may also develop scarlet fever. Five years is still the dangerous age for a communicable disease.
   (b) She has no one to help her—will be able to give better care to sick boy if younger one is away.
   (c) Richard, however, may be unhappy away from home.
   (d) She will miss the child very much.
   (e) Perhaps her sister, with children of her own, will not have time to give him adequate care.
3. Weighs the value of these factors
   (a) She does not want Richard to get scarlet fever.
   (b) If he is at home, her work may be harder but she will not worry as to what mischief he may be getting into elsewhere.
   (c) She will be careful—will try to follow instructions doctor gave—to prevent spread, etc.
   (d) He will not miss much at school—he is too young.
4. Decides what to do
   Decides to keep Richard home.
5. Respects her decision
   Feels sure entire family will be happier.
6. Acts upon it
   Tells school nurse of her decision.
7. Accepts consequences
   Realizes Richard will be exposed to scarlet fever but she will take that chance.

This woman is a changed person since her experience. She has learned a certain way of behaving.

In order to teach we must have respect for personality—we must try to understand and respect the learner's wishes and needs even though they differ from ours. The most vital element in the environment is other people. Therefore most learning takes place through constant interaction with other people. Quoting M. P. Follett in "Creative Experience": "In

human relationships there are two supreme laws of the universe—the law of evocation (calling forth) and the law of release." Each of us has something by which the other may profit and we must so treat the other that both feel free to give and take.

"I am a part of all that I have met." If we would that our patients accept part of us—the scientifis, trained and thinking skills which we want to share with our patients, families and communities—we must learn so to treat our people that we call forth the best that is in them and thus free them to become more alive, more thinking, more self-reliant. This is democrative leadership and perfect teaching.

From the report of Henrietta Landau, Assistant Educational Supervisor, Division of Public Health Nursing, in *Health News,* New York State Department of Health, November 23, 1936.

* * * * *

Advantages of Nursery Schools.—The Advantages of Nursery Schools are shown in the physical welfare and wholesome mental development of the young child. The purpose is carried out, first, by providing physical examinations and health care, second, by providing nutritious and well-planned meals, and third, by having an environment favorable to growth and a schedule of activities suited to the needs of the child.

After three years' experience with the Nursery Schools, it is our conclusion that they will continue to play a large part in the development of the young child because the Nursery Schools safeguard his health and provide supervised play facilities, assist in preventing and eliminating behavior problems, build good habits and help to socialize the child. They also show that children two years of age do take an active interest in things, they help to teach parents, as well as the children, and the program fits well with kindergarten and first grades.

C. L. OUTLAND, M.D., *Medical Director Schools, Richmond, Virginia.*

* * * * *

Secondary School Standards.—The co-operative Study of Secondary School Standards, representing the six regional associations of secondary schools and colleges in the United States, is engaged in a four-year study seeking to revise completely the methods and standards for accreditation of secondary schools in the country. It is hoped to develop criteria for evaluation of schools which will be more comprehensive, more valid, and more stimulating than any now in use. Much greater emphasis is being placed on the educational program and the outcome, much less on the machinery of the school. Tentative criteria are now being tried out in a nation-wide experimental program covering two hundred secondary schools of a wide variety of types in every state. Some sections of the tentative criteria deal directly with health education and several others have important implications in this field.

WALTER C. EELS, PH.D. *Co-ordinator of Research.*

The Summer Round-Up.—The report showing the general summary of results of the 1935 campaign on "The Summer Round-Up of the Children" carried out under the guidance of the National Congress of Parents and Teachers, shows that of the 187,453 children entering school in the kindergarten or first grade in districts where the Round-Up was carried on 95,467 received the Round-Up examination, and that 20,430 were examined by the family physician. There were present at the examination of the children 72,127 parents or guardians. Of those examined 41,192 were reported as needing medical care, and 34,952 as needing dental care. Of the medical cases 15,820, or 38 per cent, received medical care. Of the dental cases 13,754, or 39 per cent, received dental care. The total number of defects discovered was 126,618. Of these defects 32 per cent are reported as having been corrected. This is an improvement over the results of the campaign of the summer of 1933, when, of the defects, 29 per cent were corrected.

* * * * *

Tonsil Infections.—In an attempt to determine whether tonsil infections are becoming less frequent and less severe, we ask ourselves if any factors have been operating to lessen infection.

It would seem that first of all we must give due credit to the custom, now almost universal, of pasteurizing milk. In this respect the tonsils have become practically freed from infection by the tubercle bacillus and the streptococcus insofar as infections of this sort have been milk borne.

Raw milk is often the sole factor in bringing to the throat these infections and these can too often result in disability and death.

It would seem that the factor next in importance has been the wide spread immunization against diphtheria, with consequent lessening of the amount of load to be carried by tonsil tissue.

Other matters relating to tonsil infection refer to the disuse of so-called pacifiers—to the abandonment of the nipple at an earlier age, to the filling of cavities in temporary as well as permanent teeth, and to instruction regarding the washing of hands before they touch the lips.

Worthy of consideration is the fact that tonsils which appear badly diseased in children who live in the least favored conditions of our cities seem to return almost to normal after a stay of a few weeks in the country.

If, in addition to all these measures, we get a successful method of immunization against scarlet fever it would seem that most, if not all, of the serious infections of tonsil tissue would be eliminated.

Where tonsils are so badly diseased that colds seem to occur in rapid succession; where there is definite hindrance to respiration; when there is malnutrition, apparently due to infected tonsils, or where there is purulent otitis, the child should be referred to a competent nose and throat specialist. —Gardner N. Cobb, M.D., *School Physician, Boylston, Massachusetts. Contact,* October, 1936, Massachusetts Department of Public Health.

Undulant Fever.—"Epidemiologically, undulant fever is not one disease but a group of three closely related diseases . . . caused by three varieties of Brucella which differ as to animal host, mode of dissemination, pathogenicity and probably infectivity for man." This is one of several interesting observations recorded by A. V. Hardy, M.D., New York, C. F. Jordan, M.D., Des Moines, Iowa, and I. H. Borts, M.D., Iowa City, following study of a series of 1080 Iowa cases, comparative data collected from various states through the National Institute of Health, and supplementary information drawn from the current literature.

Variations in types of undulant fever are explainable, according to these investigators, on the basis that geographically in this country the bovine variety of Brucella is widely and rather uniformly distributed, while the porcine and caprine varieties are confined largely to specific localities.*

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NOTES

These notes can be successfully interesting only if members of the Association send to the editor news items concerning members, programs, and new or interesting activities.

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The Summer-Fall, 1936 Catalogue of Dental Educational Material has been put out by the Bureau of Public Relations, American Dental Association, 212 East Superior Street, Chicago, Illinois, and may be ordered from this address. It offers a very wide selection of material to be used in various educational media, at nominal prices. Included are pamphlets, talks for lay audiences, radio talks, stories, plays and rhymes, dental programs, newspaper releases, (gratis for the local press), posters, charts, first and fourth grade material, and a complete list of the American Dental Association's motion picture film service, slide service, and exhibits.

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More money for immunization and less for contagious disease hospitals should be the slogan of all progressive health departments.

* * * * *

While medicine retains the reputation of being able to cope with individual health, civic and governmental bodies have begun to tinker with community health independently of organized medicine.

It is this tinkering with health blindly that produces actual as well as potential embarrassment to the medical profession. The problem becomes particularly acute when, as has happened on numerous occasions, plans had been made for health projects without the knowledge and approval of the Medical Society.—*Omaha-Douglas County Medical Society Bulletin.*

*"In regions where any considerable portion of the milk used is unpasteurized, the bovine variety of undulant fever may become a definite menace to the health of school children. In some sections of this country it seems to be becoming increasingly prevalent. Ed.

The Health Service Section of the Division of Service of the Los Angeles City School District publishes a bulletin, under the direction of Sven Lokrantz, M.D., Director, entitled Health News. The issue of November and December, 1936, has two articles by members of the American Association of School Physicians; one on "How to Prevent a Cold" by Dr. Lokrantz, and the other on "School Health in China" by C. Morley Sellery, M.D. Several years ago, for a considerable period of time, Dr. Sellery was in charge of a mission hospital in the interior of China.

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